CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

Revised October 29, 1999

H.R. 3075
Medicare Balanced Budget Refinement Act of 1999

As ordered reported by the House Committee on Ways and Means on October 21, 1999

SUMMARY

The Medicare Balanced Budget Refinement Act would modify Medicare's payment rates for many services, including those furnished by hospitals, skilled nursing facilities, home health agencies, physicians, physical and speech therapists, occupational therapists, and managed care plans. In addition, the bill includes technical provisions that would have no effect on federal spending.

CBO estimates that the bill would increase federal direct spending by $0.5 billion in fiscal year 2000, by $10.5 billion over the 2000-2004 period, and by a total of $17.2 billion over the 2000-2009 period. Because the bill would increase direct spending, pay-as-you-go procedures would apply.

H.R. 3075 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). However, the increases to the Medicare Part B premiums would result in additional state expenditures for Medicaid totaling about $70 million over the 2000-2004 period. The bill contains one private-sector mandate as defined in UMRA. CBO estimates that its cost would be well below the threshold specified in UMRA ($100 million in 1996, adjusted annually for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 3075 is shown in the following table. The costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

	Outlays, By Fiscal Year, in Billions of Dollars				
	2000	2001	2002	2003	2004
CHANGES IN DIRECT SPENDING					
Medicare					
Hospital Inpatient Provisions	0	0.5	0.3	0.1	0.1
Hospital Outpatient Department Provisions	0.1	0.4	0.7	0.6	0.2
Skilled Nursing Facility Provisions	0.2	0.5	0.5	0.4	0.4
Physician Update	0	0.3	0.1	-0.1	-0.3
Home Health Provisions	c	1.0	0.3	c	c
Rural Provisions	c	0.1	0.2	0.2	0.1
Managed Care Provisions	c	0.4	0.4	0.6	0.1
Other Provisions	0.2	0.3	0.3	0.3	0.3
Interaction of Fee-for-Service Provisions and Medicare+Choice Payment Rates [a]	0	0.8	0.5	0.4	0.2
Subtotal, Gross Medicare Outlays	0.5	4.3	3.3	2.4	1.1
Part B Premium Receipts	0	-0.4	-0.4	-0.3	-0.1
Subtotal, Net Medicare Outlays	0.5	3.9	2.9	2.1	1.1
Medicaid Interaction with Part B Premium [b]	c	c	c	c	c
Total Changes	0.5	4.0	2.9	2.1	1.1

Note: Components may not sum to totals because of rounding.

a. The effect of changes in per-enrollee spending in the fee-for-service sector on payment rates for enrollees in Medicare+Choice plans.
b. The federal share of Medicaid payments for Part B premiums on behalf of certain low-income Medicare enrollees.
c. Costs or savings of less than $50 million.

BASIS OF ESTIMATE

Medicare

Compared with spending projected under current law, the bill would increase Medicare outlays by $0.5 billion in fiscal year 2000 and by $10.4 billion over the 2000-2004 period. The following sections discuss changes in gross outlays directly attributable to provisions of the bill. In addition, the estimate includes three interactions: the effect of changes in per-enrollee spending in the fee-for-service sector on payment rates for enrollees in Medicare+Choice plans, the effect of changes in Medicare Part B outlays on receipts from Part B premiums, and the effect of changes in Part B premiums on federal spending for Medicaid.

Payment rates for Medicare+Choice plans are based on spending in the fee-for-service sector, so provisions of the bill that increase fee-for-service spending would lead to higher payments to Medicare+Choice plans, beginning in 2001. No interaction with Medicare+Choice payments would occur in 2000 because the rates for 2000 have already been published and will not be adjusted unless services covered by the Medicare program change; the bill would not change covered services. CBO estimates the increase in spending attributable to the interaction between fee-for-service spending and Medicare+Choice payment rates would total $1.9 billion during the 2000-2004 period.

Part B premiums for 2000 have already been announced and would not be changed by this bill. In subsequent years, however, about 25 percent of new Part B outlays would be covered by premium payments by beneficiaries. CBO estimates that those premium payments would total $1.1 billion from 2000 through 2004.

A change in the Medicare Part B premium affects federal Medicaid spending because Medicaid covers the cost of the Medicare Part B premium for individuals dually eligible for Medicaid and Medicare and for other low-income Medicare beneficiaries not poor enough to qualify for full Medicaid benefits. CBO estimates that by increasing the amount of the Part B premium, the bill would increase federal Medicaid costs by about $0.1 billion over the 2000-2004 period.

Hospital Inpatient Services. H.R. 3075 contains numerous provisions that would affect Medicare payments to hospitals for inpatient care. CBO estimates these provisions would increase Medicare payments by about $1 billion during the 2000-2004 period.

Prospective Payment Hospitals. Medicare's prospective payment system (PPS) for hospital inpatient services adjusts payments to reflect higher patient care costs associated with medical education. The bill would set the adjustment at 6.0 percent for every 0.1 change in the ratio of residents to beds in 2001. In 2002, the adjustment would revert to the 5.5 percent specified in current law. CBO estimates that provision would increase outlays by $0.3 billion over the 2000-2004 period.

The bill also requires that Medicare's payment formula for its share of the direct costs of medical education be revised in a budget-neutral manner to be based on a national-average rate, adjusted for differences in local wage rates, rather than the current system in which payments are based on hospital-specific historical costs. Hospitals that would receive higher payments under the national-average rate would receive that rate immediately. However, the national-average rate would be phased in over a five-year period for hospitals that would

receive lower payments. This provision would increase spending by $0.3 billion during 2000 through 2004.

Hospitals that serve a large number of low-income patients receive a "disproportionate share" adjustment to their prospective payment rates. The Balanced Budget Act of 1997 (BBA) reduced those adjustments by 4 percent in 2001 and by 5 percent in 2002. The bill would limit those reductions to 3 percent in 2001 and 4 percent in 2002, which would increase spending by less than $0.1 billion during the 2000-2004 period.

PPS-exempt Hospitals. Hospitals that generally do not provide acute care services are exempted from the PPS and are paid on the basis of target amounts, (that is, hospital-specific historical costs, adjusted for inflation). The BBA capped the target amounts at the 75th percentile. The bill would adjust the 75th-percentile cap for differences in local wage rates. CBO estimates that those adjustments would increase outlays by $0.3 billion over the 2000-2004 period. The bill would also increase the bonuses paid to psychiatric and long-term care hospitals with costs during cost-reporting periods beginning in 2001 and 2002 that are below their target amounts. We estimate that provision would increase outlays by less than $50 million over five years.

The BBA required the Secretary of Health and Human Services (HHS) to develop a new PPS for inpatient services furnished by rehabilitation hospitals, and to phase-in that PPS over three years, beginning in 2001. During the transition, the bill would permit hospitals to choose the higher of the PPS payment rate or the transitional blend of PPS and hospital-specific rates. To offset the cost of that choice, the bill would reduce the PPS payment rate by 10 percent. Following analysis of claims and payment data, the Secretary would subsequently adjust payment rates to compensate hospitals or the Medicare program for the amount by which that 10-percent reduction was an over-adjustment or under-adjustment for the cost of permitting hospitals to choose the higher of PPS rates or transitional rates. CBO estimates this provision would have no effect on federal spending.

The bill also mandates that new prospective payment systems be developed for long-term and psychiatric hospitals by the Secretary of HHS by October 1, 2001, so that they may be implemented beginning in 2003. The bill would direct the Secretary to devise payment systems which are budget neutral. CBO estimates that implementing those prospective payment systems would not have a significant effect on Medicare spending.

Hospital Outpatient Department Services. The BBA required the Secretary of HHS to implement a PPS to replace cost-based reimbursement for most outpatient hospital services. The Secretary plans to implement that PPS in July 2000. Some hospitals will experience

gains under the PPS—Medicare payments will exceed the cost of providing outpatient services—while other hospitals will experience losses. The bill would reduce each hospital's loss during the first three years of the PPS, temporarily exempt cancer hospitals from the PPS, establish outlier adjustment payments for high-cost cases and transitional payments for certain drugs, biologicals, and medical devices under the PPS, and limit the beneficiary copayment for an outpatient hospital procedure to the Medicare Part A deductible. CBO estimates that those provisions would increase Medicare expenditures by $0.1 billion in 2000 and by $2.0 billion over the 2000-2004 period.

Skilled Nursing Facilities. The bill would amend several policies enacted in the BBA regarding payment to skilled nursing facilities (SNFs). During the transition to a fully prospective payment system, H.R. 3075 would allow SNFs to elect to be paid exclusively under the federal rate, rather than a blend of federal and facility-specific rates. The bill would increase the federal rates paid for cases assigned to the extensive services, special care, or clinically complex categories by 10 percent for services provided from April 1, 2000, through September 30, 2000. The bill would increase the update to federal payment rates for 2001 by 1.8 percentage points. It would exclude specified services—ambulance services, certain prosthetic devices, chemotherapy, and procedures using radiopharmaceuticals—from the SNF PPS and permit separate billing for those services. The bill also would enable SNFs that participated in the Nursing Home Case Mix and Quality Demonstration to receive an additional payment for Part B services in the facility-specific component of their payment rates. The final provision would require Medicare to pay SNFs that treat a large share of immuno-compromised patients a 50:50 blend of the federal and facility-specific rates for service furnished through 2001. CBO estimates that those provisions would increase Medicare expenditures by $0.2 billion in 2000 and by $1.9 billion over the 2000-2004 period.

Physician Update. The BBA established payment formulas that tie the growth of per-enrollee expenditures for physician services to the growth of gross domestic product. Those formulas generate annual rate changes that oscillate widely around a smooth trend. CBO projects stable growth rates, however, because the timing of those oscillations is impossible to predict.

The bill would modify the payment formulas to reduce the oscillations around the smooth trend. CBO estimates this provision would not change spending in 2000 and would not change cumulative spending during the 2000-2004 period. Compared to current law, however, payments to physicians would be higher in 2001 and 2002 and lower in 2003 and 2004.

Home Health. The bill would amend three policies enacted in the BBA regarding payment to home health agencies. First, it would lower the surety bond requirement for some agencies, eliminate the requirement that agencies have separate bonds for Medicare and Medicaid, and no longer require agencies to hold bonds after 4 years. Second, it would eliminate the contingency reduction and delay the 15-percent cut mandated in BBA until one year after the PPS for home health services is implemented. Third, it would pay home health agencies $10 per beneficiary served during their cost reporting period beginning in 2000. Those policies would increase Medicare expenditures by less than $50 million in 2000 and by $1.4 billion over the 2000-2004 period.

Rural Provisions. Sole community hospitals are paid the highest of PPS payment rates or their average cost per patient in 1982 or 1987, adjusted for inflation. The bill would allow sole community hospitals that currently receive PPS payment rates to choose between PPS rates and a blend of those rates and their inflation-adjusted costs in 1996. CBO estimates that provision would increase Medicare spending by $0.1 billion during 2000 through 2004.

The BBA created a new classification of limited-service hospitals, called Critical Access Hospitals (CAHs), which are exempted from the PPS. Those hospitals are limited to providing inpatient hospital stays no longer than 96 hours (with case-by-case exceptions). The bill would allow longer inpatient stays in CAHs, provided that stays average 96 hours; and it would permit investor-owned and closed or converted facilities to qualify as CAHs. CBO assumes those provisions would make it more attractive for facilities that meet the size and geographic eligibility requirements to obtain certification as a CAH, and would increase Medicare outlays by exempting more inpatient stays from the PPS. CBO estimates that those provisions would increase Medicare outlays by less than $50 million in 2000 and by $0.3 billion over the 2000-2004 period.

The bill would extend for five years the Medicare-dependent small rural hospital program (which will expire at the end of 2000), require the Secretary to permit certain hospitals located in urban areas to be reclassified as rural, and make other changes to the geographic classification system, which would allow these hospitals to obtain higher payment rates. The bill would enable all hospitals in rural areas with up to 100 beds to have swing beds, and also would expand access to paramedic services in rural areas. Those provisions would not affect spending in 2000, but would increase spending by $0.2 billion during 2001 through 2004.

Finally, the bill would allow rural teaching hospitals and hospitals with accredited rural graduate medical education programs to increase the number of residency positions above the limits established by the BBA. Those provisions would increase spending by less than

$50 million a year, with a cumulative increase in spending of $0.1 billion during the 2000-2004 period.

Managed Care. The bill would slow the implementation of adjustment of Medicare+Choice payment rates to more accurately reflect differences in cost per enrollee that are associated with health status. CBO estimates that this provision would not change spending in 2000, but would increase Medicare spending by $1.1 billion over the 2001-2004 period.

H.R. 3075 would authorize $60 million a year for payments to hospitals with nursing and allied health education programs when they provide inpatient care to patients enrolled in a Medicare+Choice plan, but would offset that spending with reductions in payments to hospitals with graduate medical education programs. Thus, CBO estimates that provision would have no effect on Medicare spending.

Other provisions would make the administration of the Medicare+Choice program more flexible by allowing beneficiaries more time to enroll in Medicare+Choice or medigap plans when plans withdraw from markets, increasing Medicare+Choice payments for plans entering counties that had been without Medicare+Choice plans since 1997, allowing cost contracts with health maintenance organizations to be renewed until December 31, 2004, expanding the types of Medicare+Choice plans that may be offered by religious fraternal benefit societies, and easing certain requirements that limit how potential providers design and market managed care products to offer to Medicare beneficiaries. In addition, the bill would modify and extend a number of demonstration projects. Those provisions would increase federal spending by $0.6 billion during 2000 through 2004.

Other Medicare Provisions. The bill includes numerous other modifications of Medicare law that are either technical in nature—that is, they have no effect on federal spending—or would result in relatively small changes in Medicare spending. The additional provisions that would affect Medicare spending are discussed below. In total, CBO estimates that these other provisions would increase Medicare outlays by $1.2 billion over the 2000-2004 period.

Outpatient Therapy Services. The BBA established annual limits on per-beneficiary payments for outpatient therapy services provided by independent therapists, comprehensive outpatient rehabilitation facilities (CORFs), SNFs, and other nonhospital providers. The limits are a $1,500 combined annual cap on physical therapy and speech language pathology services, and a $1,500 annual cap on occupational therapy services. The bill would create separate $1,500 caps for physical therapy and for speech language pathology, implement the caps on a per-facility rather than a per-beneficiary basis, and authorize transitional outlier payments for high-cost beneficiaries. We estimate that this provision would increase Medicare expenditures by $0.1 billion in 2000 and by $0.6 billion over the 2000-2004 period.

Renal Dialysis. The bill would increase Medicare's composite rate for renal dialysis by 1.2 percent beginning in January 2000 and an additional 1.2 percent beginning in January 2001. That provision would increase Medicare expenditures by less than $50 million in 2000 and by $0.3 billion over the 2000-2004 period.

Durable Medical Equipment and Oxygen. The bill would update Medicare's payment rate for durable medical equipment and oxygen by the consumer price index for all urban consumers less 2 percentage points in 2001 and 2002. That provision would have no budgetary effect in 2000, but would increase Medicare expenditures by $0.1 billion over the 2001-2004 period.

Pap Smears. The bill would increase Medicare's payment rate for the clinical laboratory component of pap smear tests. That provision would increase Medicare expenditures by less than $50 million in 2000 and $0.1 billion over the 2000-2004 period.

Inherent Reasonableness Authority. The BBA granted the Secretary of HHS the authority to adjust Medicare Part B payment rates when they are not "inherently reasonable." The bill would suspend the Secretary's authority to use the inherent reasonableness provision until publication of a new proposed rule and a final rule. That provision would increase Medicare expenditures by less than $50 million over the 2000-2004 period.

Ambulance Demonstration Project. The BBA authorized demonstration projects under which units of local government can contract directly with HHS to provide ambulance services under Medicare at a capitated rate. The bill would modify the capitated rate. That provision would increase Medicare expenditures by less than $50 million over the 2000-2004 period.

Telemedicine Demonstration Project. The BBA established a telemedicine demonstration project to improve primary care for diabetics living in medically underserved areas. The bill would direct the Secretary to make the award within three months of enactment and would change certain specifications of the project design. Modifications, such as altering the reimbursement rates, would affect the pattern of federal spending on the project over the 2000-2004 period. CBO estimates that this provision would increase spending by less than $5 million a year in 2000 and 2001, with offsetting reductions in 2002 and 2003. Thus, the provision would not change cumulative spending over the 2000-2004 period.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays that would be subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the budget year and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Changes in outlays	500	4,000	2,900	2,100	1,050	1,150	1,200	1,300	1,450	1,550
Changes in receipts	Not applicable									

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 3075 contains no intergovernmental mandates as defined in UMRA. However, the increases to the Medicare Part B premiums would result in additional state expenditures for Medicaid totaling about $70 million over the 2000-2004 period.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains a mandate on private-sector insurers who provide medigap coverage to Medicare beneficiaries. Under current law, Medicare beneficiaries who lose supplemental coverage because of the termination or discontinuation of the employer-sponsored supplemental plan or the HMO in which they are enrolled are entitled to purchase medigap coverage on favorable terms if they apply within 63 days of the termination of enrollment.

The bill would allow Medicare beneficiaries to obtain medigap coverage under those same favorable terms if they applied within 63 days of being notified of the pending termination or discontinuation of their plan, effectively giving them two windows of opportunity to apply. Because of restrictions on the premiums that medigap insurers may charge in these circumstances, this provision could impose costs that insurers might not immediately recover from premiums. However, because of the small additional number of beneficiaries that the provision would affect, the costs that would be imposed on medigap insurers would be well below the threshold specified in UMRA ($100 million in 1996, adjusted annually for inflation).

PREVIOUS CBO ESTIMATE

This estimate supercedes a previous estimate that was transmitted earlier today (October 29). The previous estimate included a cost of $0.2 billion over the 2000-2004 period for payments to hospitals with nursing and allied health programs when they provide inpatient care to patients enrolled in a Medicare+Choice plan. However, that provision would have no cost. This revised estimate corrects the error in the previous estimate.

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